STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020464	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAVA CARE OF ST FRANCIS II	3620 E DENTON AVE BAYVIEW, WI 53235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 02/17/2026, Surveyors conducted three complaint investigations and a self-report review at Adava Care of St. Francis II, a Community-Based Residential Facility (CBRF) in St. Francis, WI. Four deficiencies were identified. 2 of 3 complaints substantiated. 1 complaint unsubstantiated. Census: 19	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by:	N 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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N 158	Continued From page 1 Based on record review and interview, the provider did not ensure safety of all residents after learning of an allegation of misappropriation of Resident 8's property on 12/13/2024 and the provider did not report the misappropriation of Resident 8's property to the Department within 7 days of learning misappropriation occurred at the provider's facility. Findings include: On 02/02/2025, the Department received a self-report from Regional Director of Operations (RDOO) C, reporting the following: "Incident Description: St. Francis police department came into the building asking to speak with [Resident 8]. After speaking to [Resident 8] law enforcement officer asked if [s/he] could talk to [RDOO] C in private, law enforcement officer came into the office and stated [Resident 8] made a police report about money being stolen and money being withdrawn from the ATM with [his/her] debit card. Law enforcement officer reported that the person that used the card to withdraw the money also went to the store to purchase items. Law enforcement officer showed [RDOO] C a video of the person that used the card at the store and the person was [Caregiver D], [s/he] is 2nd shift care staff at [this facility]." On 02/17/2026, Surveyors reviewed Resident 8's record and identified the following: -Resident 8 was admitted to the provider's facility on 10/12/2023 with diagnosis including intellectual disability and cognitive communication disorder. On 02/17/2026, Surveyors conducted a self-report review regarding misappropriation.	N 158		

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N 158	Continued From page 2 Surveyors requested entire investigation documentation from Administrator A. On 02/17/2026, Surveyors reviewed [Resident 8] investigation documentation, written by RDOO C, documented the following: -"On 12/13/2024-12/17/2024: [Resident 8] had been complaining that $65 was missing from [his/her] wallet. Staff (Caregiver E, Caregiver F, Caregiver G and Caregiver H) [sic] that they did not believe [Resident 8] had money missing and dismissed [his/her] concerns due to [his/her] cognitive deficiencies. On 12/16/2024 new staff [Caregiver I] was assisting [Resident 8] and [s/he] made statements to [Caregiver I], [Caregiver I] reported concerns and spoke with different staff regarding [Resident 8] concerns. Staff [sic] that [Caregiver I] often talked about believing [Resident 8] and felt that [Resident 8] did not make the situation up. [Caregiver I] states everyone was aware the $65 was missing, which was verified by several caregivers. [Caregiver I], [Caregiver E] and [Caregiver F] stated that [Resident 8] would state [s/he] knew [Caregiver D] took it because [s/he] started calling in for [his/her] shifts. [Caregiver J] states that [s/he] normally worked with [Caregiver D] and [Caregiver F] during [his/her] shifts however those caregivers always serviced [Resident 8]. Several staff state that [Caregiver D] and [Caregiver F] have a different type of relationship with [Resident 8]. [Resident 8] would speak more openly with [Caregiver D] and [Caregiver F] as well as them spending a lot of time in [his/her] room. [Caregiver D] would spend a majority of [his/her] shift with [Resident 8] when working with [Caregiver J]. [Resident 8] continued to talk about the $65 almost daily this conversation stopped for a few weeks.	N 158		

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N 158	Continued From page 3 On 01/24/2025: Between the hours of 9am-11am [Law enforcement officer] arrived at [this facility] to investigate the complaint. Law enforcement officer spoke with [Associate Administrator] B (privately in his/her office) after seeing [Resident 8]. At approximately 2:24 pm [Law enforcement officer] returned and took [Caregiver D] away from the building to get a statement. [Associate Administrator] B states that [s/he] was informed of the theft of cash and card when meeting with the officer. [Associate Administrator] B also states that [Law enforcement officer] showed [him/her] a video depicting the image of [Caregiver D] completing transactions with [Resident 8's] bank card. [Associate Administrator] B allowed [Caregiver D] to return to work completing [his/her] shift. On 01/28/2025: [Caregiver D] was suspended pending investigation. On 02/03/2025: [Caregiver D] was terminated effective 02/03/2025 police continue to work the case on their end. Caregiver misconduct is being completed." There was no information regarding facility correction/response to the late reporting of misappropriation. On 02/17/2026, at approximately 12:40 PM, Surveyors interviewed Administrator A. Administrator A reported if an incident involving late reporting or anything that needs immediate correction s/he would get the staff in-service as soon as possible. Administrator A reported s/he would have staff sign off on the in-service. Administrator A reported s/he was not employed at this facility at the time of the above	N 158		

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N 158	Continued From page 4 misappropriation occurrence. Administrator A reported after reviewing facility records and speaking to Licensee K it should be noted the facility did not have an in-service after late reporting of misappropriation.	N 158		
N 428	83.38(1)(d) Community activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Community activities. The CBRF shall provide information and assistance to facilitate participation in personal and community activities. The CBRF shall develop, update and make available to all residents, monthly schedules and notices of community activities, including costs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide monthly schedules of community events and assist with arranging services for 1 of 1 resident (Resident 1) who wanted to go into the community. Resident 1 wanted to spend time in the community shopping, and no community activities were arranged. Findings include: On 02/04/2026, the Department received a complaint alleging the provider did not assist residents with arranging services for community events.	N 428		

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N 428	Continued From page 5 On 02/17/2026, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's facility on 05/01/2025. -Resident 1 was his/her own person. -Resident 1's Individual Service Plan (ISP), dated 08/28/2025, documented the following: "Shopping Assistance: Goal: [Resident 1 will complete shopping trips successfully with minimal assistance. Intervention: Staff to assist with shopping trips. Person/Location: Staff/At community. Frequency: [Weekly]. Schedule: Shift 1 - AM." On 02/17/2026, at approximately 11:15 AM, Surveyors interviewed Administrator A. Administrator A confirmed facility did not offer or go on community activities and outings. Administrator A reported facility has used the term "community" to refer to inside this facility. Administrator A reported facility is working on getting a van so they could do more activities and transport their residents. On 02/17/2026, at approximately 11:33 AM, Surveyors reviewed February 2026 Activity Schedule. The Activity schedule did not have any community events identified. On 02/17/2026, at approximately 11:44 AM, Surveyors interviewed Resident 1. Resident 1 reported s/he didn't get opportunities to go in the community. Resident 1 reported s/he wanted to go shopping and hasn't been able to go shopping since s/he moved in 8 months ago.	N 428		

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N 489	Continued From page 6	N 489		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all rooms were kept free from odors. There was a pungent urine smell near front entrance of facility and outside of Resident 2's, Resident 3's, Resident 4's and Resident 5's rooms. Findings include: On 08/25/2025, the Department received a complaint alleging there is a strong urine smell throughout the facility. On 02/17/2026, at approximately 9:52 AM, Surveyors observed a pungent urine smell upon entrance in facility. On 02/17/2056, at approximately 10:36 AM, Surveyors toured the facility. The hallway outside Resident 2's, Resident 3's, Resident 4's and Resident 5's rooms had a pungent urine smell. On 02/17/2026, at approximately 12:54 PM, Surveyors interviewed Resident 7. Resident 7 reported that Resident 6 urinates on his/herself in the dining room at every mealtime. Resident 7 stated s/he is so embarrassed for Resident 6. Resident 7 reported the home smells like urine because of Resident 6. Resident 7 reported s/he sits right next to Resident 6 at meals and the urine leaks all over the floor. Resident 7 reported the staff come mop it up, but the smell sticks in	N 489		

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N 489	Continued From page 7 his/her nose and "just turns my stomach." On 02/17/2026, at approximately 1:08 PM, Surveyors interviewed Administrator A. Administrator A reported the staff are responsible for doing any as needed cleaning throughout the day. Administrator A reported Resident 5 and Resident 6 have some incontinence. Administrator A reported Resident 5 has refused changing after s/he has had incontinence in his/her bed. Administrator A reported Resident 5's sister has helped with encouraging him/her to be clean, because his/her bathing and cleanliness were reasons s/he had to leave his/her last placement. Administrator A reported Resident 6 is on hospice and likes to be independent. Administrator A reported staff have found that Resident 6's depend leaked due to improper placement, it has leaked onto the floor at times. Administrator A reported the staff try to check Resident 6's depend to ensure proper placement, but it's not always caught when s/he has an improperly placed depend.	N 489		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all doors were able to be opened from the inside with one-hand, one-motion operations without having to turn the locks on doors to exit 3 of 4 doors, affecting 19 of 19 residents residing in the facility.	N 639		

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N 639	Continued From page 8 Findings include: On 02/04/2026, the Department received a complaint alleging the back door is kept locked at all times, posing a fire hazard. On 02/17/2026, at approximately 10: 38 AM, Surveyors observed the door handles on the doors leading to the exterior of the home. There were 3 doors to the exterior of the home and identified as emergency exits. The door located east rear (labeled 3) and the door located west rear (labeled 4) both were equipped with door handles which had a turning lock. When the handles were in the locked position, they would not open without turning the switch on the door handle. The door located in the middle near the office had a keypad that needs a code typed in to exit. On 02/17/2026, at approximately 10:46 AM, Surveyors interviewed Administrator A regarding the door handles and keypad. Administrator A confirmed the above-mentioned issues regarding the door handles and keypad. Administrator A confirmed door handles were not equipped with one-hand, one-motion operations. Administrator A reported the door located in the middle near the office required a code to be typed into exit. Administrator A reported s/he will have the maintenance person change the handles.	N 639		